2555 Enterprise Road
Building 9 – Suite 11-1
Clearwater, FL 33763

Family & Adolescent Counseling Services

Phone: (727) 213-5379
Fax: (727) 213-5370
www.SAYHELP.net

Restoring Relationships and Hope in Individuals and Families

Client Information

DATE:_____

Client Name _____DOB _____ Age ____
Address_____
City _____State _____ Zip Code _____
Home Phone_____ Work Phone _____ Cell Phone _____
E-mail:_____ Appointment reminder (check one) ☐ phone ☐ text ☐ e-mail
Do you want this billed to insurance? _____If so, Insurance Company_____
Policy, Member or Subscriber ID# _____
IF NOT PRIMARY INSURED - NAME OF PRIMARY INSURED AND DOB_____

If Client is a Minor
Parent Name _____DOB_____
Parent Address_____
City _____ Zip Code _____ Referred by_____
Home Phone_____ Work Phone _____ Cell Phone _____
E-mail: _____ Contact preference: phone or e-mail?_____
Employer Name _____ Occupation_____

If Client is a Minor
Parent Name _____ DOB_____
Parent Address_____
City _____ Zip Code _____
Home Phone_____ Work Phone _____ Cell Phone _____
E-mail _____ Contact preference: phone or e-mail? _____
Employer Name _____ Occupation_____

Other Household Members
Names - Ages - Relationship

_____
_____
_____

Current Medications – Names, Dosages, and Prescribing Doctor

_____
_____
_____

Reason for seeking treatment at this time

_____
_____
_____

PLEASE COMPLETE BOTH SIDES OR CONTINUE NEXT PAGE

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Informed Consent for Treatment and Office Procedures

During your initial visit you will be asked to complete forms which will consist of new client information forms, informed consent for treatment, and a release of information (if needed). The number of sessions required for treatment will depend on the issues to be addressed, the recommendations made in the treatment plan, and your commitment to working through the treatment. You are free at any time to terminate treatment if you wish. If you have behavioral health insurance coverage FACS will direct bill to your insurance company. Be advised you are fully responsible for any co-pays, co-insurance and any amounts your insurance company does not pay. By signing this consent, you authorize FACS to bill and receive payment from your insurance company on your behalf.

Therapy Sessions are **45-55 minutes** in duration. **Cancellations require a 24-hour notice and if such notice is not given, the session will be billed $75 fee.** Checks/Debit Transactions returned by your bank will be assessed a $35.00 non-sufficient funds charge. If any clinician from FACS is subpoenaed for a deposition or to testify in court, the session will be billed at the usual hourly rate, plus travel time billed at the same rate. Evaluations/reports for court cases, social security, and other written reports and treatment summaries etc. will also be charged at the usual hourly rate prorated in 30-minute segments. These are **not** billable to insurance. **We do not provide Mediation, Parent Coordination, or expert testimony for civil family court matters.**

Your information will be kept **strictly confidential** (as required by law). Absolutely no information will be released about you or your treatment to anyone without your written authorization and consent. There are exceptions to confidentiality as listed below:

- **I understand the Limitations of Confidentiality as noted below:**
  - **Duty to Warn and Protect -** When a client discloses intentions or a plan to harm self or another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client up to and including involuntary hospitalization under Florida Statute 394.467– (Florida Baker Act)
  - **Abuse of Children and Vulnerable Adults -** If a client states or suggests that a child or vulnerable adult has been abused or is in danger of being abused, the mental health professional is required to report this information to the appropriate social service and/or legal authorities including the Florida Child Abuse Hotline.
  - **Insurance Providers -** (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients to fulfil billing and payment requirements. Information may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I am voluntarily entering treatment for myself or my child whom I have rights to make medical decisions and give my consent for treatment. The rights, risks and benefits associated with the treatment have been explained to me. I consent to the evaluation and treatment process with Family & Adolescent Counseling Services

- I understand that I have the right to withdraw from treatment at any time
- I have read and understand the Privacy Policy set forth by HIPAA ***(attached to clipboard and available to you)***
- Missing or cancelling three appointments without 24-hour notice will result in services being terminated. Initial here _____
- Providers are required to communicate with your Primary Care Physician when the patient agrees.
  - _____ (initial) **I decline to have FACS communicate with my physician.**
  - _____ (initial) **I agree to have FACS communicate with my physician.**

Primary Care Physician	Address - City, State, Zip	Phone/Fax

_____ _____
Printed Name of Client Date

_____ _____
Signature of client; if under 18, Signature of Parent/Legal Guardian Signature of Witness